

This information is strictly confidential and will be used as an aid in providing necessary health care while you are a student. It will not be released to anyone except on proper authorization.

**Health Center
Central Christian College
McPherson, KS 67460**

If you have not had a complete physical in the last 2 years, it is **HIGHLY RECOMMENDED**, but not required, that you consider procuring one prior to entry into college.

MEDICAL HISTORY

Name _____ Sex _____ Age _____
Last First Middle

Date of Birth ____/____/____ Home Phone (____) _____ Cell Phone (____) _____

Home Address _____
Street City State Zip

In case of emergency, contact: _____

Relationship _____ Home Phone (____) _____ Cell Phone (____) _____

Address of Contact: _____
Street City State Zip

Family Physician _____ Address _____ Phone (____) _____

Marital Status: Single Married Widowed Divorced Religion (optional) _____

Class on Entrance to Central: Freshman Sophomore Junior Senior Race (optional) _____

Date of Last Physical Exam by Physician _____ Results _____

••• All students must be covered by a health insurance policy. •••

Health Insurance Co. _____

Policy No. _____ Under Parent's Policy: Yes No If yes, age coverage ends _____

Mental Health Coverage: Yes No If yes, give Co. name and Policy No. _____

Family History

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Sisters					
Brothers					

Has any relative (father, mother, sister, brother, or grandparent) suffered from the following? Yes No Relationship

Tuberculosis			
Heart Disease			
Chronic Kidney Disease			
Cancer			
Goiter (Thyroid Disease)			
Diabetes			
Epilepsy			
Asthma			
Hay Fever			
Mental Disorder			
Abnormal Bleeding Tendency			
Arthritis			
High Blood Pressure			
Migraine Headaches			

Immunization History - Required

The State of Kansas requires written proof of Meningitis vaccination for all on-campus students. (complete documentation from doctor or health department required)

	Year Initial Series	Year Last Booster
Tetanus		
Meningitis		
MMR		
2nd MMR		

Hepatitis B Vaccine Yes No
(recommended)

— REQUIRED —

FOR ALL INTERNATIONAL STUDENTS

TUBERCULOSIS SCREENING (Required for entrance)
 TB screening must be done within 12 months prior to date of entry.
 May be obtained at Public Health Department.

Test _____ Date _____ Results _____

Chest X-Ray _____ Date _____ Results _____

PERSONAL HEALTH HISTORY

Please answer all questions and comment on "yes" answers in the space provided below (dates, complications, etc.)

Have you had:

A. CHILDHOOD DISEASES

	Yes	No
Measles (regular, hard, red) . . .		
Measles (German, 3 day)		
Chicken Pox		
Scarlet Fever		
Diphtheria		
Whooping Cough		
Mumps		

B. ACUTE DISEASES

	Yes	No
Rheumatic Fever		
Hepatitis		
Poliomyelitis		
Infectious Mononucleosis		
Recurrent painful, draining ear		
"Strep Throat": repeated bouts		
Pneumonia		
Urinary Tract Infection		
Venereal Disease		

C. CHRONIC OR CONTINUING PROBLEMS

	Yes	No
Diabetes		
High Blood Pressure		
Arthritis		
Convulsions or Seizures		
Depression		
Malaria		
Colitis or Colon Problems		
Gastric or Duodenal Ulcer		
Asthma		
Hay Fever		
Nephritis or Nephrosis		
Congenital Heart Problems		
Heart Disease		
Diminished Hearing		
Severe Visual Problem		
Gall Bladder or Liver Disease		
Chronic Cough		

	Yes	No
Anemia		
Abnormal Bleeding Tendency		
Cancer		
Frequent Indigestion		
Excessive Drinking/Drug Use		
Rupture		
Dizziness or Fainting Spells		
Excessive Worry		
Recurrent Headaches		
Chronic Skin Problems		
"Trick" Knee		
Chronic Back Problem		
Tuberculosis		
Leukemia		
Sinusitis		
Other (specify below)		

Comments On Above:

Females: Onset Menses Age _____
 Duration days _____

CIRCLE: Regular Irregular
 Heavy Medium Light
 No Pain Mild Severe

Number of Pregnancies _____
 Complication _____
 On Oral Contraceptive? _____
 If yes, specify _____

HAVE YOU HAD:

Surgery? (kind and year): _____

Serious Injury? (head, broken bones, etc.): _____

Allergies? Drugs (specify): _____

Foods (specify): _____

Animals (specify): _____

Other (specify): _____

Do you need Allergy Shots? _____

(Campus medical staff is not allowed to administer allergy shots.)

Psychiatric or Psychological Counseling? (Over 6 visits) _____

PLEASE LIST AND DESCRIBE:

1) Medicines taken regularly and why: _____

2) Permanent Physical Disability: _____

3) Disability which limits activity: _____

4) Disability which prevents taking Physical Education: _____

If No. 3 or 4 are applicable, you need a signed statement from your physician explaining limitations.

DESCRIPTIVE HISTORY

Height _____ Weight _____ Eye Color _____

Hair Color _____ Distinguishing Characteristics _____

I hereby certify that the above history is complete to the best of my knowledge.

_____ Date

_____ Signature of Student